HOME HEALTH SERVICES
APPENDICES

APPENDIX 1
HOME HEALTH AND PRIVATE DUTY NURSING PROCEDURE CODES

Procedure Code	Place of Service	Type of Service	Service
W9919	4	1	Home Health - Physical Therapy
W9920	4	1	Home Health - Occupational Therapy
W9921	4	1	Home Health - Speech Therapy
W9925	4	1	Ongoing Assessment
W9930	4	1	Home Health Nursing Initial Visit
W9931	4	1	Home Health Aide Initial Visit
W9940	4	1	Home Health Nursing Subsequent Visit
W9941	4	1	Home Health Aide Subsequent Visit
W9045	0,4	1	Private Duty LPN
W9046	0,4	1	Private Duty RN
W9030*	0,4	1	Private Duty LPN
W9031*	0,4	1	Private Duty RN

* When used for services to recipients under age 21, these codes will price at higher rates.

APPENDIX 2
LIST OF FORMS TO BE SUBMITTED WITH PA/RF

Discipline	**Form(s)**
Home health nursing	HCFA 485 - required with new and renewal requests HCFA 486 - required with new and renewal requests, and required with amendments, unless the HCFA 486 submitted with the approved PA/RF is still current. HCFA 487 - optional
Home health aide	HCFA 485 - required with new and renewal requests HCFA 486 - required with new and renewal requests, unless a Home Care Assessment or Home care Assessment Update is submitted; and required with amendments, unless the HCFA 486 submitted with the approved PA/RF is still current, or a Home Care Assessment Update is submitted because a Home Care Assessment was previously submitted. HCFA 487 - optional
Home health therapies	PA/HHTA - required with new and renewal requests INITIAL THERAPY EVALUATION or summary of recent re-evaluation - required with all requests HCFA 485 - required with new and renewal requests HCFA 486 - optional HCFA 487 - optional IEP - Individualized Education Plan required for child (0-21), or document why none IFSP - Individualized Family for Service Plan required for any child participating in the Birth to Three Program
Private duty nursing	HCFA 485 - required with new and renewal requests HCFA 486 - required with all requests, including amendments HCFA 487 - optional
Personal care worker	Home Care Assessment - required with requests Home Care Assessment Update - required with renewal requests, including amendments Physician's Orders or HCFA 485
Durable medical equipment	PA/DMEA - required with all requests HCFA 485 - required with new and renewal requests Physician Orders - required with amendments HCFA 486 - optional HCFA 487 - optional

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Use 999 - "Other" only if the requested category of service is not found in the list. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

* 120 - Home Health/Private Duty Nursing Services/Home Health Therapy/Respiratory Care Services
  121 - Personal Care Services
  130 - Durable Medical Equipment
  131 - Drugs
  132 - Disposable Medical Supplies
  999 - Other (use only if the requested category of service is not listed above)

* Includes PT, OT, Speech, and may include personal care provided by dually-certified home health agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the recipient's current medical condition.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (Not Required)

ELEMENT 13 - FIRST DATE OF TREATMENT (Not Required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element. When the procedure may be one of two at any given time, request both procedure codes (W9045/W9046, W9930/W9940).

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by WMAP policy and the coding structure used) for each service/procedure/item requested.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
4	Home

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested.

Numeric	Description
1	Medical (including: Home Health, Independent Nurses, PT, OT, ST, Personal Care, Respiratory Care)
P	Purchase New DME
R	DME Rental

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate Revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

When requesting home health services, indicate the number of visits per day/number of days per week times the total number of weeks being requested.

When requesting personal care or private duty nursing services, indicate the number of hours per day/number of days per week times the total number of weeks being requested.

If sharing a case with another provider, enter "shared case" and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the PPOC.

When requesting two procedure codes to be used interchangeably (W9045/W9046), include a statement that the total number of hours will not exceed the combined total number of hours ordered on the PPOC.

When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits due to (number of) continuous hours of care."

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Home Health (number of visits)
Home Health Therapy-PT, OT, Speech (number of visits)
Personal Care (number of hours)
Private Duty Nursing (number of hours)
Respiratory Care Services (number of hours)

For home health services based on visits, providers must figure the quantity of visits as follows:

1. Total each procedure code separately.

2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

   When one visit per day is requested, the actual number of days in the authorization period equals the total number of visits requested.

3. Divide the total number of days approved by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.

4. Calculate, for each code, the total number of days per week.

5. Multiply the total of visits approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

   Procedure code:

   W9930 - 1v/day, 3 days/week
   W9931 - 1v/day, 7 days/week

2. Total days requested:

   Start Date 6/5/91 End Date 12/31/91

   Total days requested = 200

3. Total weeks requested:

   200/7 = 28.6, round up to 29 weeks

4. Total services requested:

   W9930 - 3 visits per week x 29 weeks = 87 visits
   W9931 - 1 visit per day x 200 days = 200 visits

For private duty nursing, respiratory care, and personal care services based on hours, providers must figure the quantity of hours as follows:

1. Total each procedure code separately.

2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

3. Divide the total number of days requested by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.

4. Calculate, for each code, the total number of days per week.

5. Multiply the total of hours approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

   Procedure code:

   W9045 - 4hrs./day, 3 days/week
   W9046 - 7hrs./day, 7 days/week

2. Total days requested:

   Start Date 6/5/91 End Date 12/31/91

   Total days requested = 200

3. Total weeks requested:

   200/7 = 28.6, round up to 29 weeks

4. Total services requested:

   W9045 - 4 hours per day, 3 days per week x 29 weeks = 348 hours
   W9046 - 7 hours per day x 200 days = 1,400 hours

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

In the blank space to the right of element 24, please indicate the start and end date for which services are being requested. (Not required for DME/DMS items.)–If backdating is requested, specify backdating and indicate reason for need.

NOTE: The dates indicated for requested start and end dates do not guarantee the same authorization grant and expiration date.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 4
SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
PRIVATE DUTY NURSING SERVICES

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M.Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654321
10 DX: PRIMARY: 344.0 quadraplegia
11 DX: SECONDARY: 599.0 urinary tract infection
12 START DATE OF SOI: MM/DD/YY
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9045/W9046		4	1	LPN/RN - private duty nursing	1400	XXXX.XX
				8 hrs/day x 7 days/week x 25 weeks		
				(total hours not to exceed 8 hrs/day		
				per PPOC)		
					TOTAL CHARGE	21 XXXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY
end: MM/DD/YY

23 MM/DD/YY (DATE)
24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

GRANT DATE
EXPIRATION DATE
PROCEDURE(S) AUTHORIZED
QUANTITY AUTHORIZED: ***

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the WMAP professional consultant.

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 4a
SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
HOME HEALTH NURSING SERVICES

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654321
10 DX: PRIMARY: 401.9 - hypertension NOS
11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)
12 START DATE OF SOI: N/A
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9930		4	1	HHN - initial visit	16	XXX.XX
				1 visit/day x 2 days/wk x 8 weeks		
W9930		4	1	HHN - initial visit	2	XX.XX
				1 visit PRN/month x 2 months		
					TOTAL CHARGE	21 XXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY
end: MM/DD/YY

23 MM/DD/YY (DATE) 24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
GRANT DATE | EXPIRATION DATE
PROCEDURE(S) AUTHORIZED | QUANTITY AUTHORIZED: ***
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the WMAP professional consultant.

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 4b
SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
HOME HEALTH NURSING AND AIDE SERVICES

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M [ ] F [X]
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO: 87654321
10 DX: PRIMARY: 401.9 hypertension NOS
11 DX: SECONDARY: 250.0 diabetes II (NIDDM)
12 START DATE OF SOI: N/A
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9930		4	1	HHN - initial visit	87	XXX.XX
				1 visit/day x 3 days/wk x 29 weeks		
W9931		4	1	HHA - initial visit	203	XXX.XX
				1 visit/day x 7 days/week x 29 weeks		
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)
24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)
start: 6/5/91
end: 12/31/91

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
[ ] APPROVED
GRANT DATE
EXPIRATION DATE
PROCEDURE(S) AUTHORIZED
QUANTITY AUTHORIZED: ***
[ ] MODIFIED – REASON:
[ ] DENIED – REASON:
[ ] RETURN – REASON:

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the WMAP professional consultant.

DATE
CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 4c
SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
HOME HEALTH THERAPY

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 120

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow
Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
10 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO: 87654321

10 DX: PRIMARY: 429.2 - CVA

11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)

12 START DATE OF SOI: N/A

13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9919		4	1	HH - physical therapy	78	XXXX.XX
				1 visit/day x 3 days/week x 26 weeks		
					TOTAL CHARGE	21 XXXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY
end: MM/DD/YY

23 MM/DD/YY (DATE)

24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED ***

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the WMAP professional consultant.

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 4d
SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
DME

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M. Provider, 10 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 87654321
10 DX: PRIMARY: 401.9 - hypertension NOS
11 DX: SECONDARY: 250.0 - diabetes II (NIDDM)
12 START DATE OF SOI: N/A
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W0900		4	P	Commode	1	XX.XX
					TOTAL CHARGE	21 XX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 I. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
☐ MODIFIED — REASON:
☐ DENIED — REASON:
☐ RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120